COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Minutes
2-8-2016
COPIC, Mile High Room

Members Present: Bill Lindsay (chair), Cindy Sovine-Miller (vice-chair), Elisabeth Arenales, Sue Birch, Jeff Cain, Alicia Caldwell, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman (phone), Marcy Morrison, Dorothy Perry, Marguerite Salazar, Chris Tholen

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Meeting Minutes:

I) Approval of the Minutes

A) Approval of the January 11, 2016 minutes were moved by Marcy Morrison and seconded by Ira Gorman.

B) There were no changes to the minutes which were adopted unanimously by the Commission.

II) Market Place Consolidation - Dr. Bob Berenson, Urban Institute

A) Dr. Berenson, Institute Fellow at the Urban Institute, provided a presentation on "State Approaches to Addressing the Effects of Provider Consolidation and Market Power." The presentation is available on the Commission website.

B) Commission discussion and questions:

1) Can you provide examples where active purchasing has been effective?
   (a) Too early to know if there has been success, would look at California and Rhode Island to see how it has worked there.
2) Colorado's ratio of Medicare payment to cost has been under the 95 percent marker used in the presentation, what can we draw from that, if anything? If this is true across the state, does that mean prices tend to be higher in Colorado or are there other factors to consider?
   (a) I would say prices are standard across the country. Variations in prices have to do with wage index, hospital experimentation, and other things. There can be some distortion in how prices are calculated. For purposes of this discussion, point is that any variations in payment to cost ratios has to reflect services in Medicare. It seems states throughout the Midwest are being penalized for having relatively efficient health care systems. Would interpret this that Colorado is relatively efficient in terms of service use and this isn't a bad thing on behalf of the citizenry.
3) The Commission has had discussion on the definition of the term "price," just want to clarify if you are talking about price paid?
   (a) Yes, talking about transaction price. What is the price that the buyer pays the seller; not the charge.
4) In your example, you mentioned Massachusetts bans carriers from creating contracts that guarantee provider participation, can you explain what they were trying to accomplish?
   (a) The state was trying to avoid a situation where a dominant provider is able to put into contract a provision and negotiated rate saying they have to be in the contract and approved.

III) Maryland Hospital Association: Hospital Rate Settings - Carmela Coyle, CEO

A) Carmela Coyle, CEO of the Maryland Hospital Association, provided a status update on Maryland's All Payer pilot program. The presentation is available on the Commission website.

B) Commission discussion and questions:

1) Does this impact all hospitals in Maryland?
   (a) Yes, each and every hospital is under this plan in the state with one exception for a new hospital that will be on a global budget.
2) What is the composition of the state agency that does the rate settings?
   (a) It is a seven member commission and the chair is only allowed to vote to break a tie. The commission determines the rates set in the state. The criteria for membership is quite wide; the law is written so that one individual represents hospitals and all members are appointed by the Governor. The commission basically has a hospital, payer, physician and four other representatives with a $15 billion field.
   (b) Is the physician representative in an independent practice or can they be affiliated with a hospital?
      (i) They could be either, but at the moment it is a physician affiliated with a private practice.
3) Is there data available around Medicaid savings?
   (a) State savings in first year was $16M. Because Maryland is an all-payer state, when we save money on Medicare and Medicaid we save money for the consumers as well.
4) Do you intend to track or see trends in the cost to consumers on health care?
   (a) It is too early to tell. This is a point of contention. The dominant payers are very supportive of the rate setting model. Our rate setting system has traditionally kept care more affordable from the commercial perspective. Hospitals will be watching closely and would like to pass on savings to consumers.
5) How do you handle free standing ERs in terms of controlling costs?
   (a) Maryland currently has three free standing ERs and their rates are set by the state commission. There is legislation this session that would allow hospitals to convert inpatient capacity into free standing medical facilities. What we are finding is that as we implement this model, it doesn't make sense to continue to invest capital into traditional inpatient facilities and we really need strengthened ambulatory care capacity. We are looking to create more options to allow for more, without forcing hospitals to close in their communities.
6) One observation is that 3.58 percent per person is a lot higher than what we get in Colorado; would submit that Colorado is further along than Maryland as related to this one metric. On slide 14 - enabling infrastructure, I would submit that the Denver metro area is pretty far along with every one of these data points.
   (a) 3.58 percent is not what Maryland received, it is the absolute rate ceiling.
7) Can you expand on the comment on uninsured on slide 3?
   (a) If you are not Medicare, Medicaid or commercially insured – the price you are charged is not more than what everyone else pays. In this case, Maryland built in uncompensated care into rates. It is one reason we don't have public facilities in the state of Maryland.
8) One quality metric is to reduce complications, how are you measuring the reduction of complications?
   (a) We have a different program to monitor complications. It is a system based on comparison of rate that is expected to the actual rate achieved. Maryland has a system of rewards and penalties based on that. Talking about things like blood stream infections, UTIs, and other potentially preventable complications.
   (b) Colorado has a similar program but it is not based on penalties.
9) Is CMS considering allowing other states to enter into these kinds of waivers?
   (a) CMS is interested in opening to other states. They are actively considering the concept of a global budge but there are some challenges to address.

C) FOLLOW-UP: Additional questions for Maryland Hospital Association. Staff to ask these questions of Carmela and provide more details.
   1) How long did it take to bring this group together and how long did the conversations go on until Maryland got to this point?
   2) Better understanding of the process to get here, was it a legislative process?
   3) How they produced data analytics.

IV) Colorado Association of Health Plans (CAHP)/American Health Insurance Plans (AHIP) Stakeholder Discussion – Charlie Sheffield, CAHP and Dianne Bricker, AHIP

A) Charlie Sheffield, CAHP and Dianne Bricker, AHIP provided a joint presentation based on their stakeholder questionnaire provided to the Commission. The presentation can be found on the Commission website.

B) Commission discussion and questions:
   1) Is the fact that we are seeing more integration of providers and hospitals and then the facility fee gets attached to bills when patients see their provider, is that a significant cost driver?
      (a) I don't believe the facility fee itself is the major cost driver, but there is an internal conflict there to look at.
   2) Are free standing ERs typically part of a larger system or are they individual?
      (a) We are seeing health systems acquiring these individual networks. Hard to say if this is an emerging trend at this point.
   3) If premiums are 15 to 22 percent lower the fear from a consumer perspective is that narrow networks leave out the preeminent specialists so they are narrowed in a way that people with certain conditions are left out of certain networks.
      (a) A survey showed that 90 percent of members are happy with provider choice. We are not seeing that the vast majority are unhappy. The number one concern to consumers right now are price points and this is one way to reduce premiums.
      (b) Who was surveyed to come up with this number?
         (i) McKenzie & Co. did the survey.
   4) What is the number of tiered or narrowed networks in Colorado and are they comprised of groups or individuals?
      (a) Do not know the answer, but will get those numbers to Commissioners (Charlie Sheffield).
   5) What types of alternative payments and incentive structures is CAHP advocating?
      (a) That is on the federal level and can provide more information to the Commission (Charlie Sheffield).
   6) There are insurance consolidations coming up, what can we expect to see as a result in the next few years?
      (a) Greater efficiency from the networks. There is a lot of efficiency to be had in consolidation and there are legitimate reasons for acquisitions and consolidations. Should look at what the effects will be for the consumer and overall health care dollar.
   7) The complexity of care is making it more challenging for effective care to be efficient – to do this, you have to change the way you do payments and do it across payers. How do we get to a place where we can coordinate across payers towards quality incentives?
      (a) The industry has been engaged in projects that speak to those issues. Payers agree there are efficiencies to be had in standardizing care. When we talk about uniformity across carriers, this discussion has to be on the highest level. Will continue to get together at the state level to have these conversations, but from the national level this doesn't create uniformity if each state comes up with their own path.

(b) Colorado is the only state to have a signed MOU between payers and the state related to CPCI.

8) As we talk about narrow networks, we need to keep in mind that Kaiser is a good example of one that has low costs.
9) Do consumers fully understand what it is they are buying into with narrow networks? Sometimes there is a shock of what you have purchased and what the limitations are.
10) Have pharmaceutical folks and health plans come to the table to try to look at the future of what is going on with health care and effects to the consumer?
    (a) This is a priority and suspect some changes will come about.

C) FOLLOW-UP: Dianne Bricker will follow-up to the Commission with suggestions on what the state can do on prescription drug costs.
1) HB16-1102 – transparency on drug pricing
2) Patent reform
3) Hold drug companies to same access and affordability standards that apply to the rest of the health care system

V) Physical Therapy/Rehab Stakeholder Discussion – Dr. Cam McDonald, President American Physical Therapy Association (APTA) and Dr. Timothy Flynn

A) Dr. Cam McDonald, President of American Physical Therapy Association, and Dr. Timothy Flynn provided a presentation on "Get PT First: a value based approach to modernizing health care in Colorado." The presentation can be found on the Commission website.

B) Commission discussion and questions:
1) Key question after seeing this presentation is, so what do we do about it? You would think insurance companies would be doing this given the available data. What can we do to get to the point you are talking about?
    (a) Many insurance companies haven't bought into this for unknown reason.
    (b) There is a big focus on price, this is a model that helps reduce the quantity of services. Insurance companies are focused on price and this model changes the model of care. This is pushing a value based model and is something new that we haven't seen insurance companies embrace yet.
2) I like to see that the APCD is being used to help with this data. Would like to know if Medicaid data has been parceled out in this research. This would be great data to take to the benefits collaborative to look at if there should be realignment with the benefit for Medicaid.
3) I'm into getting folks into quick and early PT if it provides the best collaborative care for the patient in a way that makes sense at the right time.
4) Because it didn't work well to go to the health plans, my recommendation was to come to Cost Commission to include the value of what they bring into our recommendations. I believe what they bring will help bring costs down. We should promote the value of PT.
    (a) The Commission has talked about workforce, one way might be to have a recommendation about scope of practice for PT. Some of this includes the involvement of the physician.
5) Question is how to engage in this conversation. If this is a system that becomes increasingly patient driven, the fact of the matter is that not everybody who starts off in PT will avoid the other steps, some people will need to be in a medical channel. We ought to work together in the area where patients are in the medical channel. How do you create this conversation of bringing a physician component into this as well because members will listen to their primary care doctor?
    (a) Need to look at this in multiple ways to get to the fix.

C) FOLLOW-UP: Several states have benefits and technology committees that put forward protocols and suggestions, I would ask staff to think about how to bring back information on those commissions that would be useful for our work.
   1) Is there a way to recommend a body in the state that looks at methodologies and delivery systems? A group with background and expertise to really look at range of treatments that might be treated. This seems to be more on the higher level than the Commission is trying to look at.

VI) Payment and Delivery Reform – Dr. Mike Volz, Colorado Medical Society
   A) Dr. Volz provided a presentation on payment and delivery reform, and provided a recommendation that the Commission not limit its recommendations on payment and delivery reform to bundling payments. CMS advocates use of other payment and delivery reform models that focus on the patient, and are valid and actionable. Commission should recommend continuation of funding for Medicaid medical codes.
   B) Commission discussion and questions:
      1) How is your organization addressing issue of shortage of practitioners in some parts of the state?
         (a) The answer is complex, it has to do with in or out of network, acceptance of different health plans, etc. CMS has been trying to attract more physicians and keeping physicians trained in the state to stay in the state. Feel the bigger issue is access to care however you do it. Telehealth is one example that has helped consolidate some of this problem.
      2) Is it true most medical graduates are going into specialties opposed to general practice?
         (a) It depends on the school. Trying to determine the right number of doctors is very tough to do.
      3) What do you see as trajectory for micro-practices (practices with one or two physicians)?
         (a) My belief is there is always going to be a substantial need for small practices. Physicians have their own goals and what drives them to do work; there are a number who would quit medicine if they had to become an employee. Given economic theory, as long as there is a need for specialized services there will always be physicians to provide that service for the patient. In my estimate, I don't see it going down below 25 percent.
      4) The use of patient centered medical homes and reflecting on prior presentation on PT, is it realistic for a physician to be in some sort of relationship with the physical therapist and have some way to share revenue?
         (a) It is both realistic and Pollyannaish.

VII) HB16-1102 Fiscal Note - Representative Joanne Ginal
   A) Representative Joanne Ginal spoke to the Commission on the fiscal note for HB16-1102 regarding pharmaceutical pricing transparency. The fiscal note to the bill seems to be very high in comparison to what she intended the Commission to do. Would like to speak with Commissioners about how to bring it the fiscal note more in line with what the Commission is asked to do in the bill.
   B) Commissions discussion and questions
      1) Context for the broader Commission, CDPHE contacted Chris Tholen and asked for more information for the fiscal note. If the intention is to put together information on a pricing template, there was a large misunderstanding on what was expected of the Commission. While I understand the intention of the bill, it is going to be difficult to do analysis on this level of data and come up with meaningful recommendations to bring back. We had an understanding that collectively the Commission doesn't have the level of expertise to collect the data and bring back analytics. We could talk further and do modifications to the fiscal note but would also need to discuss limitations of the Commission in providing this type of analysis.

2) What happens if drug manufacturers don't come forward with data? The Commission has no ability to require or penalize them to come forward. It seems not what the Commissions was constituted to do.
   (a) There have been stakeholder meetings including pharmaceutical companies and health insurance companies. Most of this data is readily available to public on the FCC website. If it is that readily available, they should be able to come to the Commission with information requested rather quickly.
3) At this point, without continued funding the Commission will sunset in September of this year and trying to understand how we would accomplish this task with that end date.
   (a) Dates could be modified and can work with Commission on that.
4) Important to note that there will have to be significant security around these databases and don't think we can deliver on a cheaper mechanism. Think we should push for how this is going to be a national utility, there is a lot of pharmaceutical and security expertise needed for this task.
5) One reason the fiscal note number is as large as it is, is concern looking at current staff is that we have no expertise in this area. The Commission will need to hire outside expertise to undertake some of the "simple" tasks in this bill. The contracting to secure our current consultants took about 4 to 5 months, so our timeline would also likely take much longer. We need expertise to know who drug manufacturers are, what drugs are above $50,000, etc. This is a much bigger deal than the PT bill.
   (a) All that information should be available on Google.
6) Are the questions in the bill not research that the Office of Legislative Legal Services could do off session and bring back to the Commission to look at?
   (a) I did have the senior research analyst do some research on high cost of pharmaceutical drugs and treatments. I have memo I would be happy to share with the Commission.

VIII) Recommendations and Parking Lot Discussion

A) Postponed until next Commission meeting. Discussion will take place during the beginning of March's agenda.

IX) Updates and Commission Business, Bill Lindsay/Commissioners

A) Bylaws revision for election of officers
   1) Planning Committee made proposed bylaw revisions because the Commission has been unable to have 100 percent of members present at a Commission meeting. The changes to the bylaws can be seen in the link provided above.
   2) Discussion:
      (a) Option b makes the most sense, everyone has a say with a ballot but we don't need 100 percent of members to be present.
   3) Motion to approve option b
      (a) In order to make a vote on the revisions, the Commission needs two-thirds of voting members present and a 30 day notice.
   4) Formal notification given providing 30 day notice of the vote at the March 14th Commission meeting.
B) Chris will bring forward a recommendation around transparency on end of life care for patients to understand what their options are.
C) Proposed agenda for statewide meetings to be provided to Commissioners at next meeting.
D) Budget request:

1) The Commission won't know where we stand with our budget request until March. The JBC has been supportive, but the state does has some significant fiscal issues, so this will be a matter of prioritization.
2) JBC figure setting will take place on February 18th, with decision to move forward into long bill on February 22nd.
3) The Planning Committee will keep the Commission posted on what the budget request is looking like and are continuing to pursue private funding sources.